Adult Developmental Services
Personal Plan Face Sheet

Identifiers

Consumer name		**Region:**
MaineCare ID #		__ **1** __ **2A** __ **3B**
EIS ID #		__ **2T** __ **3P**
ISC/CCM name		__ **2L**

Facilitator

Name of person writing this plan	
Organization	

Plan

Plan start date	___/___/____
Plan end date	___/___/___.

Plan Type __ Annual __Review/Other __ Interim

***Next Waiver reclassification date** ___/____/____ OR ____ no waiver

***Pre-Planning**

Preplanning start date ___/___/___. (see narrative)
Response Sheet Summary used in Pre-Planning with consumer/guardian ___ Yes ___ No
Reportable Events reviewed? ____Yes ____ No __ No Reportable Events
IST in past 12 months? ___ Yes ____No

***Routine Health**

Date of most recent:	
Physical exam	___/___/___.
Dental/oral exam	___/___/___.
IV sedation for dental/oral procedure? __Y __ N	___/___/___.
Vision exam (if needed)	___/___/___.
Hearing exam (if needed)	___/___/___.
Psychotropic meds __ Y __ N Reviews 1. By psychiatrist? __ Y __ N 2. By psychiatrist? __ Y __ N	 ___/___/___. ___/___/___.
Mortuary Trust (age 50+ only)__ Yes __ No	

Current Medical Providers	
Name	**Specialty**

Planning Coordinator signature _____ Date ___/___/___.

Action Plan (To be completed by ISC/CCM)

Unmet needs are identified? ___Yes (see narrative) __ No unmet needs
Plan for assessing consumer satisfaction? __ Yes __ No
Planning team monitoring schedule:

This plan accurately reflects the planning process and the person's needs and desires. The recommended services are medically necessary and in compliance with MaineCare rules

ISC/CCM Signature _____ Date___/___/___.

* these items are required for the annual plan only

Revised 11/27/07